008198

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01848
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST LUCIEN MIDDLE J LAST AUBE		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 2 1986	2b. HOUR 6:00PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. / IF UNDER 1 YEAR: MONTHS DAYS / IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mich,	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrian	12b. KIND OF BUSINESS OR INDUSTRY Ind.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Del.	13b. COUNTY New Castle	13c. CITY OR TOWN New Caslte	13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS / ZIP CODE 238 Sykes Rd. 19720			
14. FATHER'S NAME FIRST Joseph A. MIDDLE Aube LAST		15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE Bovenous LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	(IF YES GIVE WAR OR DATES) WW II Korea	16b. SOCIAL SECURITY NO. 233 52 3207	17. INFORMANT Mary T. Aube ADDRESS 238 Sykes Rd. New Castle, Del. 19720

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) CARDIAC ARRHYTHMIA

DUE TO, OR AS A CONSEQUENCE OF

(c) ALZHERMERS DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 14, 19 84, to JANUARY 2, 19 86, that (I) (we) last saw the deceased alive on JANUARY 2, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Joseph Coudon MD	DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH COUDON	22e. ADDRESS VA MEDICAL CENTER PERRY POINT MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-6-86	23c. NAME OF CEMETERY OR CREMATORY All Saints	23d. LOCATION (CITY OR TOWN, STATE) Newark New Castle Del.
24. FUNERAL DIRECTOR NAME SPICER MULLIKIN FUNERAL HOME ADDRESS NEW CASTLE DE		25a. DATE REC'D. BY REGISTRAR JAN 6 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the coroner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

038068

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 01849

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles MIDDLE: Thomas LAST: Bias, Jr.				2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 1 DAY 30 YEAR 1986	2b. HOUR M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Jul.21,1961	6. AGE (IN YEARS LAST BIRTHDAY): 24 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH 1 DAY 30 YEAR 1986	2d. HOUR 1:52A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.	
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Delaware	13b. COUNTY: New Castle	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 2 Wenark Drive/Oak Tree	
14. FATHER'S NAME FIRST MIDDLE LAST: Charles Thomas Bias, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: June Williams (Bias)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 175-56-2148		17. INFORMANT: Charles T. Bias, Sr. ADDRESS: 2WenarkDr.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocarditis

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural Causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1/30/86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/5/86	23c. NAME OF CEMETERY OR CREMATORY: Grace Lawn Mem.Park	23d. LOCATION CITY OR TOWN COUNTY STATE: New Castle, Delaware
24. FUNERAL DIRECTOR NAME ADDRESS: Leroy O. Dyett 4600 Lib.Hghts.Ave.		25a. DATE REC'D. BY REGISTRAR: FEB 05 1986	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY INFORMATION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 41

DHMH - 17 (VR A1S ME (S))

023103

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01850

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: HAMMIE / / BOYKIN SR,		2a. DATE OF DEATH MONTH DAY YEAR: January 16, 1986	2b. HOUR: 9:00am
3. SEX: M	4. RACE: B	5. DATE OF BIRTH MONTH DAY YEAR: 1 23 15	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S. A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND	13b. COUNTY:	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 1321 SILVERTHORNE RD. 21239

14. FATHER'S NAME FIRST / MIDDLE / LAST: TOM / / BOYKIN		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: ANNIE / / MURRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 577-16-4408	17. INFORMANT ADDRESS: LILLIE M. ROBINSON 1321 SILVERTHORN RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of prostate w/metastasis to bone and lungs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that [X] (this hospital) attended the deceased from January 13, 19 86, to January 16, 1986 [ ] (this hospital) [X] (I) last saw the deceased alive on the date above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Roy W. Chesnut, Jr.	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 1-16-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROY W. CHESNUT, M.D.	22e. ADDRESS: VA Medical Center, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 1-22-86	23c. NAME OF CEMETERY OR CREMATORY: ARBUTUS	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ARBUTUS / / MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: March Funeral Home, Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR: JAN 21 1986	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

035006

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01851

1. DECEASED NAME (TYPE OR PRINT) FIRST: Archie MIDDLE: C. LAST: Bramble

2a. DATE OF DEATH MONTH DAY YEAR: January 24, 1986

2b. HOUR: 4:10pm

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: March 15 1907

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: Mechanic

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: #8 Carry Back Dr. Elkton

14. FATHER'S NAME FIRST: Fred MIDDLE: LAST: Bramble

15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: LAST: Koch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 212-09-7729

17. INFORMANT: Deborah Benson ADDRESS: 7 Hatteras Ct. Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Arrest. (Respiratory)

DUE TO, OR AS A CONSEQUENCE OF (b): Advr COPD. pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD.

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/22, 19 80, to 1/24, 19 86, that (I) (we) last saw the deceased alive on 1/24, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/25/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jui Chih Hsu

22e. ADDRESS: 223 West main st. Elkton Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 27, 86

23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.

23d. LOCATION CITY OR TOWN: Elkton COUNTY: Cecil STATE: Md.

24. FUNERAL DIRECTOR NAME: Edward McKown ADDRESS: GEE Funeral Home 259 E. MAIN St. Elkton

25a. DATE REC'D. BY REGISTRAR: JAN 29 1986

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in 24 hours after death.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

035035

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 0 1 8 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST: George MIDDLE: W. LAST: Bryant

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR: 01-28 19 86

2b. HOUR: PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: 06-30-21

6. AGE (IN YEARS LAST BIRTHDAY): 64Y YRS.

IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 01-28 19 86

2d. HOUR: 448P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tenn

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil Co, Elkton, Md

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired

12b. KIND OF BUSINESS OR INDUSTRY: Truck Driver

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES ☑ NO ☒

13e. STREET ADDRESS: 166 Blake Rd 21921

14. FATHER'S NAME FIRST MIDDLE LAST: UNKNOWN

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Fannie Canter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 186-16-0371

17. INFORMANT ADDRESS: Merwin Bryant son same address 398-1543

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atherosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-28-86

EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitale, MD ADDRESS Union Hospital Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 1, 1986

23c. NAME OF CEMETERY OR CREMATORY: MILLER FAMILY CEMETERY

23d. LOCATION CITY OR TOWN: TRADE COUNTY: JOHNSON STATE: CO. TENN.

24. FUNERAL DIRECTOR NAME: Ralph E. Hicks ADDRESS: HICKS HOME for FUNERALS ELKTON, MD. 21921

25a. DATE REC'D. BY REGISTRAR: JAN 31 1986

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

031106

STATE OF MARYLAND 86 018 53
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Birtie M. Carter

2a. DATE OF DEATH MONTH DAY YEAR: January 25, 1986

2b. HOUR: 12:30 P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Sept. 11 1908

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: North East

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Turkey Point Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nursing Aid

12b. KIND OF BUSINESS OR INDUSTRY: Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Rising Sun

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 449 McGrady Rd. 21911

14. FATHER'S NAME FIRST MIDDLE LAST: Willaim Delp

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mary Roberts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 235-38-7971

17. INFORMANT: Norma Aleshire ADDRESS: P.O. Box 127 North East, Md. 21901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebralvascular accident

DUE TO, OR AS A CONSEQUENCE OF (b) hypertension cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: K Corrin Jr MDA DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): K.M.Corrin, Jr., M.D.

22e. ADDRESS: 304 North Street, Suite 2 Elkton, Md., 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-28-86

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Rising Sun Cecil Md.

24. FUNERAL DIRECTOR NAME: Robert T. Chronk ADDRESS: Funeral Home North East, Md.

24a. DATE RECEIVED BY REGISTRAR: JAN 29 1986

24b. REGISTRAR'S NAME: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82 (VRA 15, 4)

030022

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 01854
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST HOWARD MIDDLE J. LAST CLEARY
2a. DATE OF DEATH MONTH 1 DAY 24 YEAR 86
2b. HOUR M
3. SEX Male
4. RACE White
5. DATE OF BIRTH MONTH 04 DAY 08 YEAR 09
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Conowingo
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 122 Rock Springs Rd.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent
12b. KIND OF BUSINESS OR INDUSTRY N.Y. City Transit Authority
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD
13b. COUNTY Cecil
13c. CITY OR TOWN Conowingo
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE 122 Rock Springs Rd. 21918
14. FATHER'S NAME FIRST Sylvester MIDDLE A. LAST Cleary
15. MOTHER'S MAIDEN NAME FIRST Aimme MIDDLE LAST Wendt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO
(IF YES, GIVE WAR OR DATES) — — — —
16b. SOCIAL SECURITY NO. 088070411
17. INFORMANT Teresa Cleary, ADDRESS 122 Rock Springs Rd Conowingo Md 21918

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung with
DUE TO, OR AS A CONSEQUENCE OF (b) widespread metastases
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED 1/24/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold L. McWilliams, MD
22e. ADDRESS 200 Milton Road Fallston, MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation
23b. DATE 1-28-86
23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris & Co
23d. LOCATION CITY OR TOWN West Chester COUNTY Cecil STATE Md
24. FUNERAL DIRECTOR NAME R.T. Foard ADDRESS Rising Sun Md.
25a. DATE [illegible] JAN 28 [illegible] REGISTRAR'S SIGNATURE [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

020270

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01855
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BENJAMIN MIDDLE: FRANK LAST: Colten		2a. DATE OF DEATH MONTH DAY YEAR: JAN 12 1986	2b. HOUR: 6:10 PM
3. SEX: M	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JAN 27 1911	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: CALVERT MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Calvert Manor Nurs. Home, Inc.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: FARM
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pennsylvania	13b. COUNTY: CHESTER	13c. CITY OR TOWN: Cochranville	13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET ADDRESS / ZIP CODE: R.D. 2 19330 99999
14. FATHER'S NAME FIRST: FRANK MIDDLE: LAST: Colten		15. MOTHER'S MAIDEN NAME FIRST: Minnie MIDDLE: LAST: Williams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): — — —	16b. SOCIAL SECURITY NO.: 211-20-3362	17. INFORMANT: Addie B. Colten — ADDRESS: R.D. 2 Cochranville Pa. 19330

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOGENIC CARCINOMA WITH METS, CHF

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ADENOCARCINOMA OF PROSTATE, DEBILITATION, OLD AGE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED IN THE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph F Klein	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/12/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH F KLEIN	22e. ADDRESS: BOX 189 WEST GROVE PA 19390	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 1-16-86	23c. NAME OF CEMETERY OR CREMATORY: SADSBURY FRIENDS	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SADSBURY TWP, LANCASTER CO. PA.
24. FUNERAL DIRECTOR NAME: R T FORD — ADDRESS: RISING SUN MD 21911 FUNERAL HOME		25a. DATE RECD. BY REGISTRAR: JAN 16 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified immediately.

BP 999999

DHMH - 16 60M 7/84 (VRA 15, 4)

027061

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 01856
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jordan MIDDLE: Robert LAST: Coyle

2a. DATE OF DEATH MONTH DAY YEAR: 1/11/86

2b. HOUR: 605 P.M.

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 10,1986

6. AGE (IN YEARS LAST BIRTHDAY) YRS.: IF UNDER 1 YEAR MONTHS: DAYS: 1 IF UNDER 24 HRS. HOURS: MIN.:

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.

10. CITY OR TOWN OF DEATH: ELKTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): --------

12b. KIND OF BUSINESS OR INDUSTRY: --------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: CECIL

13c. CITY OR TOWN: ELKTON

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 110 BYWOOD ROAD 21921

14. FATHER'S NAME FIRST: DAVID MIDDLE: E. LAST: COYLE

15. MOTHER'S MAIDEN NAME FIRST: ROBERTA MIDDLE: S. LAST: BRINK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: --------

17. INFORMANT: MR. DAVID E. COYLE, ELKTON, MD. 21921 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumothorax

DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral Consolidation lungs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 86, to 1/11, 19 86, that (I) (we) last saw the deceased alive on 1/11/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Vilma Tadalan MD DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/11/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Vilma F. Tadalan MD

22e. ADDRESS: Elkton Md 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 1-15-86

23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY

23d. LOCATION CITY OR TOWN COUNTY STATE: ELKTON, MARYLAND

24. FUNERAL DIRECTOR: Ralph E. Hicks

ADDRESS: HICKS HOME for FUNERALS ELKTON, MD. 21921

25a. DATE REC'D. BY REGISTRAR: JAN 23 1986

25b. REGISTRAR'S SIGNATURE: Lisa Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

020271

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01857

1. DECEASED NAME (TYPE OR PRINT) FIRST: RALPH MIDDLE: LEONARD LAST: DANDY		2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 11, 1986	2b. HOUR: 1:15P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept 19, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: --	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 2942 Huntingdon Avenue 21211
14. FATHER'S NAME FIRST MIDDLE LAST: Irving Dandy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Albertina Evert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 215-07-6597	17. INFORMANT: Earl J. Dandy	ADDRESS: 123 W. 29th Street 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that X (this hospital) attended the deceased from September 15, 19 83, to January 11, 19 86, that X (we) last saw the deceased alive on January 11 19 86, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (XXXX) view the body after death.

22b. SIGNATURE: Michael Delahunt	DEGREE: MD. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 1/11/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL DELAHUNT, M.D.		22e. ADDRESS: VA MEDICAL CENTER, PERRY POINT, MD 21902	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 01/16/86	23c. NAME OF CEMETERY OR CREMATORY: Md. Vet Cem. Garrison	23d. LOCATION CITY OR TOWN COUNTY STATE: Garrison, Balto. Co. Md.
24. FUNERAL DIRECTOR NAME: Burgee-Henss,	ADDRESS: 3631 Falls Rd., Balt, MD 21211	25a. DATE REC'D BY REGISTRAR: JAN 16 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

017154

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01858

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Madeline MIDDLE: Mary LAST: Davidson

2a. DATE OF DEATH — MONTH DAY YEAR: January 9, 1986

2b. HOUR: 1320 hrs

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: Sept. 16 1904

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS — IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OF FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Port Deposit

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 54 Rolling Hills Ranch Lane

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House Wife

12b. KIND OF BUSINESS OR INDUSTRY: ---------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pa.

13b. COUNTY: Delaware

13c. CITY OR TOWN: Chester

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2509 West 9th. St. 19013

14. FATHER'S NAME — FIRST: John MIDDLE: LAST: Mitchell

15. MOTHER'S MAIDEN NAME — FIRST: Lannie MIDDLE: LAST: Rawel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): -----

16b. SOCIAL SECURITY NO.: 166-05-7808D

17. INFORMANT: Rosemarie Linton ADDRESS: 54 Rolling Hills Ranch Lane 21904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoma c̄ Intracranial Metastasis — 8-1985 (1yr)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec, 19 85, to 1.9, 19 86, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Shailutha S Sachdev — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1.10.86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. S. Sachdev MD.

22e. ADDRESS: 204 Bow St. Elkton, Md.21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/14/86

23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

23d. LOCATION — CITY OR TOWN: Coatesville COUNTY: Chester STATE: Pa.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son Perryville, Maryland

25a. DATE REC'D. BY REGISTRAR: JAN 14 1986

25b. REGISTRAR'S SIGNATURE: Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

030004

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 01859
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mark — MIDDLE: D. — LAST: DeWolf

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH DAY YEAR: 1/24/ 19 86

2b. HOUR: M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH DAY YEAR: 12 30 1962

6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: 1/ 24/ 19 86

2d. HOUR: 12:25 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY? U.S.A

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County, MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil County

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): WORKER

12b. KIND OF BUSINESS OR INDUSTRY: Lumber Yard

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Cecil

13c. CITY OR TOWN: Rising Sun

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 773 Hopewell Rd.

14. FATHER'S NAME — FIRST: EITON — MIDDLE: A. — LAST: DeWolf

15. MOTHER'S MAIDEN NAME — FIRST: Fay — MIDDLE: L. — LAST: Rehm

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): — — —

16b. SOCIAL SECURITY NO.: 218-80-0743

17. INFORMANT — ADDRESS: Mr & Mrs. Eiton DeWolf, Tucson, Az.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple Injuries

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8161

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. MONTH DAY YEAR: 11:30PM 1/23/ 1986

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): occupant of auto/lost control/ejected

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): roadway

21f. LOCATION — STREET: Hopewell Rd. — CITY OR TOWN: Rising Sun — COUNTY: Cecil Co. — STATE: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 1/24/86

EXAMINER'S NAME (TYPE OR PRINT): Gregory R. Kauffman, M.D. ADDRESS: 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 1-27-86

23c. NAME OF CEMETERY OR CREMATORY: R.A. Ferris & Co.

23d. LOCATION — CITY OR TOWN: West Chester — COUNTY: Chester — STATE: PA.

24. FUNERAL DIRECTOR — NAME: RT Foard — ADDRESS: Rising Sun Md.

25a. DATE REC'D BY REGISTRAR OF VITAL STATISTICS: JAN 28 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP _____ DHMH - 17 (VR A1S ME (S))

020106

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 01860

1. DECEASED NAME (TYPE OR PRINT): FIRST THOMAS MIDDLE CHARLES LAST DOBILZEK

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 1 DAY 6 YEAR 86 19

2b. HOUR M

3. SEX: MALE

4. RACE: CAUCASION

5. DATE OF BIRTH: MONTH DAY YEAR 8-29-63

6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS.

IF UNDER 1 YR.: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 1-6-86 19

2d. HOUR 8:50A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Germany

7b. CITIZEN OF WHAT COUNTRY? West Germany

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Colora

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 22 Corn Cake Row

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Painter

12b. KIND OF BUSINESS OR INDUSTRY: House

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Cecil

13c. CITY OR TOWN: Colora

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS: 22 Corn Cake Row

2917

14. FATHER'S NAME: FIRST William MIDDLE LAST Stauder

15. MOTHER'S MAIDEN NAME: FIRST Inga MIDDLE LAST Dobilzek

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 225-27-5740

17. INFORMANT: Spouse: Theresa Dobilzek ADDRESS: 6828 Brian Michael Ct. Springfield, Va 22153

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shotgun wound of head

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX (HEAD ONLY) NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY: HOUR 7PM A.M. P.M. MONTH 1 DAY 6 YEAR 86 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): self/inflicted

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION: STREET 22 Corn Cake Row CITY OR TOWN Colora COUNTY Maryland STATE

22a. I certify that I took charge of the remains described above, (HEAD ONLY) Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1-7-86

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 1-9-86

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION: CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR: NAME STATE ANATOMYBOARD ADDRESS BALTIMORE, MD.

25a. DATE REC'D BY REGISTRAR: JAN 16 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" (PENDING) IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

031016

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01861

1. DECEASED NAME (TYPE OR PRINT): Henry P. Eihinger

2a. DATE OF DEATH: 1/16/86

2b. HOUR: 710P M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: July 10 1911

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: Welder

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Delaware

13b. COUNTY: Newcastle

13c. CITY OR TOWN: Middletown

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: R.D. 1 Box 496 Middletown 19709

14. FATHER'S NAME: Joseph Eihinger

15. MOTHER'S MAIDEN NAME: Elizabeth Albrecht

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 221-14-5479

17. INFORMANT: Sophie A. Eihinger

ADDRESS: RD1 Bx.496 [redacted] Middletown Md. 19709

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiopulmonary Collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic adenocarcinoma of the lungs — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c): COPD / Cigarette smoking — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): d) Dehydration

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/26, 19 85, to 1/16, 19 86, that (I) (we) last saw the deceased alive on 1/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/17/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert Denitzio MD

22e. ADDRESS: Cecilton Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 20, 1986

23c. NAME OF CEMETERY OR CREMATORY: Forrest Cemetery

23d. LOCATION: CITY OR TOWN Middletown / COUNTY NewCastle / STATE Del.

24. FUNERAL DIRECTOR NAME: Edward M. McGloin — GEE Funeral Home 259 E. Main St. Elkton

25a. DATE REC'D BY REGISTRAR: JAN 27 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BR

DHMH - 16 60M 7/84 (VRA 15, 4)

029067

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01002
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Albert C. Foreman		2a. DATE OF DEATH MONTH DAY YEAR: January 24, 1986	2b. HOUR: 5:58A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug.15,1920	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Crane Operator	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Perryman	YES [ ] NO [X]	1525 Perryman Road/21130

14. FATHER'S NAME FIRST MIDDLE LAST: John Foreman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Bertha Cullum	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 218 07 7711	17. INFORMANT ADDRESS: VAMC, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Seizure disorder

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ~~XX~~ (this hospital) attended the deceased from 6-7- 19 85, to 1-24- 19 86, that ~~XX~~ (we) last saw the deceased alive on 1-24- 19 86, and that in ~~XX~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~XXXX~~ view the body after death.

22b. SIGNATURE: Prem Lal	DEGREE: M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 1-24-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): PREM LAL, M.D.		22e. ADDRESS: VAMC, Perry Point, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan.27,1986	23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gdns	23d. LOCATION CITY OR TOWN COUNTY STATE: Bel Air,Harford,Maryland
24. FUNERAL DIRECTOR NAME ADDRESS: Tarring Funeral Home, Aberdeen, Maryland 21001-3399		25a. DATE REC'D. BY REGISTRAR: JAN 27 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson Bender

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

038097

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 01863
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Clarence MIDDLE: B. LAST: Gray

2a. DATE OF DEATH MONTH DAY YEAR: 1 29 86

2b. HOUR: 2 45 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: 9 19 1901

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvinia

7b. CITIZEN OF WHAT COUNTRY?: USA.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Rising Sun

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Calvert Manor Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Foreman

12b. KIND OF BUSINESS OR INDUSTRY: Laundry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pennsylvinia

13b. COUNTY: Chester

13c. CITY OR TOWN: Lincoln University

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: Hillview Farm, Rt 841 - 19352

14. FATHER'S NAME FIRST: Samuel MIDDLE: LAST: Gray

15. MOTHER'S MAIDEN NAME FIRST: Emma MIDDLE: LAST: Maris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 173-07-1012

17. INFORMANT: A. Samuel Gray

ADDRESS: 200 Caravel Drive Bear, Delaware 19701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiorresp. arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF (b) pneumonitis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: general cerebral AS, Alzheimers

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-80, 19 to 1-29, 19 86, that (I) (we) last saw the deceased alive on Jan 18 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Faye R. Doyle MD

DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1-30-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): FAYE R. DOYLE MD

22e. ADDRESS: 133 LOCUST ST OXFORD, PA 19363

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-1-86

23c. NAME OF CEMETERY OR CREMATORY: ROSEDALE FRIENDS

23d. LOCATION CITY OR TOWN: WEST CHESTER COUNTY: CHESTER STATE: PA

24. FUNERAL DIRECTOR NAME: Robert T. Jones

ADDRESS: 122 W. MAIN

R.T JONES FUNERAL HOME NEWARK, DEL

25a. DATE REC'D. BY REGISTRAR: FEB 05 1986

25b. REGISTRAR'S SIGNATURE: Marlon Randall

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must complete page 2.

017049

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01864

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Thomas MIDDLE William LAST Gregor

2a. DATE OF DEATH: MONTH Jan. DAY 2 YEAR 1986

2b. HOUR: 4:00 A.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH April DAY 23 YEAR 1907

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rumford, Maine

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired - Electrician

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: Laurelwood Nursing Center

14. FATHER'S NAME: FIRST John MIDDLE Wood LAST Gregor

15. MOTHER'S MAIDEN NAME: FIRST Hamilton MIDDLE LAST Cornwall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-20-0223

17. INFORMANT: Suzanne G. Adams ADDRESS: Box 75 Ocean City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-30, 19 85, to 1-2, 19 86, that (I) (we) last saw the deceased alive on 1-1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gelendre. Najera

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1-2-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Rolando A. Najera, M.D.

22e. ADDRESS: 105 E, Main St., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Jan. 4, 1986

23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris

23d. LOCATION: CITY OR TOWN West Chester COUNTY Chester STATE Pa.

24. FUNERAL DIRECTOR: NAME Gee Funeral Home, P.A. ADDRESS Elkton, Md.

25a. DATE RECEIVED BY REGISTRAR: JAN 9 1986

25b. REGISTRAR'S SIGNATURE: Jane Davidson Randolph

041003

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 01865
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: EDETHEL PRESTON HASSON

2a. DATE OF DEATH MONTH DAY YEAR: 1 19 86

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Aug. 18, 1910

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Rising Sun

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Calvert Manor Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 802 Paradise Road/210 01

14. FATHER'S NAME FIRST MIDDLE LAST: Grover C. Preston

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Agnes Viola Carty

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 217-01-1573

17. INFORMANT ADDRESS: J.H.Miller, 802 Paradise Rd., Aberdeen, MD, 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Adenocarcinoma of lung — 3 yrs.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-15, 1985, to 1-9, 1986, that (I) (we) last saw the deceased alive on 1-9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Neil Taylor

DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-10-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Neil Taylor MD

22e. ADDRESS: Rising Sun, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 23, 1986

23c. NAME OF CEMETERY OR CREMATORY: Rock Run Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Havre de Grace, Harford, MD

24. FUNERAL DIRECTOR NAME ADDRESS: Tarring Funeral Home, P.A, Aberdeen, MD, 21001-3399

25a. DATE REC'D. BY REGISTRAR: FEB 10 1986

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

031127

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 018666
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nelson MIDDLE: W. LAST: Heath		2a. DATE OF DEATH MONTH DAY YEAR: 01-22-86	2b. HOUR: 7:05P M
3. SEX: male	4. RACE: caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 06-25-23	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer &Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Cecil	Elkton	YES ☐ NO ☐	364 Rickett's Mill Road

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LEWIS	W.	HEATH	DORIS	M.	WRIGHT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		212 16 6695	MARY F. HEATH	,364 RICKETTS MILL RD ELKTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-21, 19 86, to 1-22, 19 86, that (I) (we) last saw the deceased alive on 1-22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Rolando A. Najera	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	1-22-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ROLANDO A. NAJERA M.D.	105 E. MAIN ST., ELKTON, MD. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	1/25/86	CHERRY HILL METH.CEM.	ELKTON / CECIL / MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HICKS HOME Ralph E. Hicks	ELKTON, MD.	JAN 29 1986	[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

BP_____

DHMH - 16 50M 7/77 (VR A 15 (4))

020107

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 01867
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Emily MIDDLE: LAST: Herod

2a. DATE OF DEATH MONTH DAY YEAR: January 6 1986

2b. HOUR: 11:00 AM

3. SEX: Female

4. RACE: Colored

5. DATE OF BIRTH MONTH DAY YEAR: Apr. 3, 1915

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 112 Collins Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY: —

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 112 Collins Avenue 21921

14. FATHER'S NAME FIRST MIDDLE LAST: unknown

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Georgiana Stevenson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: unknown

17. INFORMANT ADDRESS: Congo Funeral Home, Wilm. De.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) — Cardiac Resp. Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro Sclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/6, 1982 to 1/6, 1986 that (I) (we) last saw the deceased alive on 12/19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/6/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph G. Lanzi, MD.

22e. ADDRESS: 721 Bridge St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-11-86

23c. NAME OF CEMETERY OR ~~CREMATORY~~: Bohemia Manor Chesapeake City

23d. LOCATION CITY OR TOWN COUNTY STATE: Cecil, Md

24. FUNERAL DIRECTOR NAME ADDRESS: Gee Funeral Home, Elkton, Md

25. DATE RECEIVED BY REGISTRAR: JAN 14 1986

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

035011

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 01868

1. DECEASED NAME (TYPE OR PRINT) FIRST: George MIDDLE: T. LAST: King Jr.		2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: 1/ 24/19 86	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 23, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1/ 24/19 86	2d. HOUR: 4:52 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 86 Blossom Lane 21921	
14. FATHER'S NAME FIRST: George MIDDLE: T. LAST: King Sr.		15. MOTHER'S MAIDEN NAME FIRST: Gertrude MIDDLE: LAST: Barber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 214-03-0815	17. INFORMANT: Suzanne King	ADDRESS: 86 Blossom Lane Elkton	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 1/24/86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan. 27, 1986	23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery	23d. LOCATION CITY OR TOWN: Elkton COUNTY: Cecil STATE: Maryland
24. FUNERAL DIRECTOR NAME: Edward McKeon GEE Funeral Home 259 E. Main St Elkton	25a. DATE REC'D. BY REGISTRAR: JAN 29 1986	25b. REGISTRAR'S SIGNATURE: Kathleen Randolph	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 4 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP_____ DHMH - 17 (VR A1S ME (S))

027062

STATE OF MARYLAND 86 01869

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: MARY B. KNOTT		2a. DATE OF DEATH MONTH DAY YEAR: 1/14/86	2b. HOUR: 1058 AM
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 17, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): -------	12b. KIND OF BUSINESS OR INDUSTRY: ---------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	CECIL	ELKTON	YES ☐ NO ☒	1195 AUGUSTINE HERMAN HWY. 21921

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
FENWICK NMI KNOTT	---- ---- CARTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		216-76-9540	MR. HINTZE, DIRECTOR, LINDSEY GROUP HOME, ELKTON, MARYLAND 21921

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac - Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Possible Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Status Post thoracotomy 4th Postop day

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/09/ 19 86, to 1/14 19 86, that (I) (we) last saw the deceased alive on 1/13 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Satoshi Ikeda	M.D	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/16/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Satoshi Ikeda M.D	Wilmington, Del

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	1-16-86	R.A. FERRIS CREMATORY	WEST CHESTER, PA. 19380

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE FILED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	HICKS HOME for FUNERALS, ELKTON, MD. 21921		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

028166

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01870

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: J. MIDDLE: Latimer LAST: Lynch		2a. DATE OF DEATH MONTH DAY YEAR: January 21, 1986	2b. HOUR: 4:10AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 16, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 39 North Lockwood Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Buyer	12b. KIND OF BUSINESS OR INDUSTRY: Retired

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR [redacted]	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Chesapeake	YES ☒ NO ☐	303 Bank Street 21915

14. FATHER'S NAME FIRST: Joseph MIDDLE: Rawlings LAST: Lynch		15. MOTHER'S MAIDEN NAME FIRST: Luba MIDDLE: Malvina LAST: Reed	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-01-2171	17. INFORMANT: Thomas Lynch — ADDRESS: 555 Dilworth Rd. W. Chester Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov. 6, 19 85 to _____, 19____, that (I) (we) last saw the deceased alive on 12-21-, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Yogish A. Patel	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1-22-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Yogish A. Patel, MD	22e. ADDRESS: 1700 Shallcross Ave, Wilmington, DE ~~19806~~	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan. 24, 1986	23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Chesapeake City Cecil Md.
24. FUNERAL DIRECTOR NAME: Edward Milburn ADDRESS: GEE Funeral Home 259 E. Main St Elkton		25a. DATE RECEIVED BY STATE REGISTRAR: JAN 23 1986	25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstances, in the event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

020108

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 018 71

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Ethel MIDDLE R. LAST McVey		2a. DATE OF DEATH MONTH DAY YEAR Jan. 11 1986	2b. HOUR 6:20 PM
3. SEX F	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR March 25 1891	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.
10. CITY OR TOWN OF DEATH CALVERT, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT MANOR NURS. HOME, INC.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY GOVT
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md	13b. COUNTY CECIL	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE Buckley Ave. 21911			
14. FATHER'S NAME FIRST GEORGE MIDDLE LAST Reynolds	15. MOTHER'S MAIDEN NAME FIRST LAURA MIDDLE LAST SPENCER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	(IF YES, GIVE WAR OR DATES) ------	16b. SOCIAL SECURITY NO. 215-32-5950	17. INFORMANT MRS. BETTY STONE ADDRESS 19 Buckley Ave., Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac decompensation — 4 days

DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. — many years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple small CVA's.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 15 yrs. 19____ to 1-11 19 86, that (I) (we) last saw the deceased alive on 1-11 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Neil Taylor	DEGREE MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 1-13-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD	22e. ADDRESS Rising Sun, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-14-86	23c. NAME OF CEMETERY OR CREMATORY ROSEBANK CEMETERY	23d. LOCATION CITY OR TOWN Calvert COUNTY Cecil STATE Md.
24. FUNERAL DIRECTOR NAME R.T. FOARD ADDRESS FUNERAL HOME, RISING SUN MD. 21911		25a. DATE REC'D. BY REGISTRAR JAN 16 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic result, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND 86 018712
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

024016

1. DECEASED NAME (TYPE OR PRINT) FIRST LAURA MIDDLE NMI LAST MISSIK		2a. DATE OF DEATH MONTH 1 DAY 12 YEAR 86	2b. HOUR 2300 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH APRIL DAY 5 YEAR 1888	6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEVINE HAVEN NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MARYLAND	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE DE GRACE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS 412 WEBSTER RD. 21078

14. FATHER'S NAME FIRST UNK MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST UNK MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO; (IF YES, GIVE WAR OR DATES) N/A	16b. SOCIAL SECURITY NO. 497-26-1719	17. INFORMANT RUTH V. CANLIFFE, ADDRESS SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease — Over 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c) with Cardiomyopathy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rt. lower lobe pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from JAN 16 19 85, to JAN 12 19 86, that (I) (~~we~~) last saw the deceased alive on Jan. 12 19 86, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED 1-12-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. RALPH ANDREWS M.D	22e. ADDRESS 23E Main St., Elkton Md. 21921	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL / CREMATION	23b. DATE JAN. 14, 1986	23c. NAME OF CEMETERY OR CREMATORY R.A. PERRIS & Co.	23d. LOCATION CITY OR TOWN WEST CHESTER, COUNTY CHESTER, STATE PENNA
24. FUNERAL DIRECTOR NAME TALLING FUNERAL HOME, P.A. ADDRESS ABERDEEN, MD. 21001-3399		25a. DATE REC'D. BY REGISTRAR MAR 22 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

010077

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01873

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Margaret Elizabeth Moore

2a. DATE OF DEATH MONTH DAY YEAR: Jan. 3, 1986

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Dec. 31, 1913

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: North East

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 19 Cemetery Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: North East

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 19 Cemetery Rd. 21901

14. FATHER'S NAME FIRST MIDDLE LAST: Willaim Bailey

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Elizabeth Hall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216-78-0056

17. INFORMANT: Phyllis Jianniney

ADDRESS: 19 Cemetery Rd. North EAst, Md. 21901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Parkinsons, Anemia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 1, 19 79, to January 3, 19 86, that (I) (we) last saw the deceased alive on Jan 3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 6 Jan 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-7-86

23c. NAME OF CEMETERY OR CREMATORY: North East Meth.

23d. LOCATION CITY OR TOWN COUNTY STATE: North East Cecil Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Smith Funeral Home North East, Md.

25a. DATE REC'D. BY REGISTRAR: JAN 8 1986

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

036085

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 018774

1. DECEASED NAME (TYPE OR PRINT) FIRST SUSAN MIDDLE CRIPPS LAST MORTON		2a. DATE OF DEATH MONTH DAY YEAR Jan. 29, 1986	2b. HOUR 3 PM M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1956	6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Elkton-Rural	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 Scarlett Court	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Ass't	12b. KIND OF BUSINESS OR INDUSTRY Health

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS 104 Scarlett Court 21921

14. FATHER'S NAME FIRST George MIDDLE S. LAST Cripps		15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE	LAST Brady
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 139-52-5132	17. INFORMANT Craig P. Morton ADDRESS Elkton, Md. 104 Scarlett Court,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Nasopharyngeal Carcinome

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 83 to Jan. 29, 19 86 that (I) (we) last saw the deceased alive on Jan. 24, 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE William B. Funk MD	DEGREE ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 1/29/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Funk MD	22e. ADDRESS 665 Churchman's Rd., Newark, Del. 19711	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1/30/86	23c. NAME OF CEMETERY OR CREMATORY Silverbrook	23d. LOCATION CITY OR TOWN Wilmington, COUNTY New Castle, STATE Del
24. FUNERAL DIRECTOR NAME Robert T. Jones ADDRESS Newark, Del.		25a. DATE REC'D. BY REGISTRAR FEB 03 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

031019

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 01875

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles MIDDLE: T. LAST: Natoli				2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ MONTH 1 DAY 16 YEAR 1986	2b. HOUR 1845 M
3. SEX: male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 12/10/40	6. AGE (IN YEARS, LAST BIRTHDAY): 45 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH 1 DAY 16 YEAR 1986	2d. HOUR 1845 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: English			

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Cecil	Rising Sun	YES ☐ NO ☑	207 Walnut Garden Road 21911

14. FATHER'S NAME FIRST: Thomas MIDDLE: J. LAST: Natoli		15. MOTHER'S MAIDEN NAME FIRST: Mariana MIDDLE: Stella LAST:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: Salvatore Natoli	ADDRESS: 1154 N. 11th St. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertension

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

1 pack/day smoker

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Henry Farkas, M.D. TITLE (SPECIFY) MD Asst-Deputy MEDICAL EXAMINER DATE SIGNED 1/16/86

EXAMINER'S NAME (TYPE OR PRINT) Henry Farkas, MD ADDRESS Union Hosp. of Cecil County.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan. 21, 1986	23c. NAME OF CEMETERY OR [redacted]: Getheseme	23d. LOCATION CITY OR TOWN: Nehlenburg COUNTY: Berks STATE: Pa.
24. FUNERAL DIRECTOR NAME: Edward M. McKean ADDRESS: Gee Funeral Home 259 E. Main St. Elkton Md		25a. DATE REC'D. BY REGISTRAR: JAN 27 1986	25b. REGISTRAR'S SIGNATURE: Julia Trudeau

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 (GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

030002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 01876

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: SHIRLEY R. PARKS				2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 1 DAY 16 YEAR 19 86	2b. HOUR M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH Feb. DAY 16 YEAR 14	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH 1 DAY 16 YEAR 19 86	2d. HOUR 5:25 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Smythe Cty. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cafeteria Wker.	12b. KIND OF BUSINESS OR INDUSTRY: Bd. of Ed.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Port Deposit	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 1471 Theodore Rd. 21904			
14. FATHER'S NAME FIRST / MIDDLE / LAST: Robert L Richardson				15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Sarah C. Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-46-2053		17. INFORMANT: Joel H. Parks	ADDRESS: 1471 Theodore Rd. Port Deposit, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis of the liver

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 1-17-86

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1-19-86	23c. NAME OF CEMETERY OR CREMATORY: Calvary Baptist	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rising Sun Cecil Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Brogden Funeral Home North East, Md.		25a. DATE REC'D. BY REGISTRAR: JAN 28 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rogers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. KEEP PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

016049

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 018777
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LEITHER MIDDLE: V. LAST: PRICE	2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 9, 1986	2b. HOUR: 6.03 a.m	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 17, 1903	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 10 Otter Point Road 21921
14. FATHER'S NAME FIRST: Hilton MIDDLE: L. LAST: Lewis		15. MOTHER'S MAIDEN NAME FIRST: Cosco MIDDLE: - LAST: Lewis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 226-16-1055	17. INFORMANT: Mrs. Ava Z. Sturgill ADDRESS: Elkton, Md. 21921	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal insufficiency.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, Hypertension, Diabetes mellitus

DUE TO, OR AS A CONSEQUENCE OF (c) Intestinal obstruction due to mesenteric Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I)/(this hospital) attended the deceased from 10/11, 19 73, to 1/9, 19 86 that (I) (we) last saw the deceased alive on 1/8, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jui Chih Hsu — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-9-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jui Chih Hsu — 22e. ADDRESS: 223 West main st Elk. Md 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1-11-86	23c. NAME OF CEMETERY OR CREMATORY: Knoll Krog Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Abingdon, Virginia
24. FUNERAL DIRECTOR NAME: Ralph E. Hicks ADDRESS: HICKS HOME for FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR: JAN 13 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

031052

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01878

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LAWRENCE MIDDLE: J. LAST: REDDING

2a. DATE OF DEATH MONTH DAY YEAR: January 21, 1986

2b. HOUR: 1:50pm

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH MONTH DAY YEAR: MAY 25, 1898

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Perry Point, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): VA Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PERSONNEL DIRECTOR-COAL CO.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: VIRGINIA

13b. COUNTY: ARLINGTON

13c. CITY OR TOWN: N/A

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 1600 S. JOYCE STREET 99999

14. FATHER'S NAME FIRST: HENRY MIDDLE: LAST: REDDING

15. MOTHER'S MAIDEN NAME FIRST: CATHERINE MIDDLE: LAST: CURRY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): W.W. I.

16b. SOCIAL SECURITY NO.: 177-01-2062

17. INFORMANT: CATHARINE R. CALVERT-1600 S. JOYCE ST. ARL, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic hypertensive disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinson's disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ☒ (this hospital) attended the deceased from December 26, 1985 to January 21, 1986 ~~(hours in the last)~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Julian Ocejo M.D.

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 1-21-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JULIAN OCEJO, M.D.

22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: JAN.24,1986

23c. NAME OF CEMETERY OR CREMATORY: QUANTICO NAT'L. CEM.

23d. LOCATION CITY OR TOWN COUNTY STATE: QUANTICO, VIRGINIA

24. FUNERAL DIRECTOR NAME: Arlington Funeral Home, Arlington, VA.

25a. DATE REC'D. BY REGISTRAR: JAN 27 1986

25b. REGISTRAR'S SIGNATURE: Julia Fridson Hughes

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, only the funeral director, page 3 should be detached for use on the burial-transit permit. Then these pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 99999

DHMH - 16 60M 7/84 (VRA 15, 4)

030001

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01879
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Isabelle Jane Rolfe

2a. DATE OF DEATH MONTH DAY YEAR: January 16 1986

2b. HOUR: 12:30 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Jan. 11 1914

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Perryville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Jackson Park Rd. 21903

14. FATHER'S NAME FIRST MIDDLE LAST: Elisha Atkinson

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Junietta DeHaven

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-44-8409

17. INFORMANT ADDRESS: Frances Clark Rt. 4 Box 275 Dover, Del. 19901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Sarcoma of Abdominal Wall — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Poor nutrition secondary to /

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July, 19 77, to Jan 16, 19 86, that (I) (we) last saw the deceased alive on Jan 15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles M. Hensgen MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 17 Jan 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-20-86

23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: North East Cecil Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Crouch Funeral Home North East,

24a. DATE REC'D. BY REGISTRAR: JAN 28 1986

25b. REGISTRAR'S SIGNATURE: Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

DHMH - 16 50M 4/82 (VRA 15 4)

010078

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01880

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Nancy S. Roney		2a. DATE OF DEATH MONTH DAY YEAR: January 4, 1986	2b. HOUR: 4:50 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 13, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Cecil	North East	YES ☐ NO ☒	79 Pratt Lane 21901

14. FATHER'S NAME FIRST MIDDLE LAST: Norman Davis Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Sayre Alician Perry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-54-7614	17. INFORMANT: James A. Roney — ADDRESS: 12 Valley Forge Dr. North East, Md. 21901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diagnosis

Congestive Heart Failure, Gastritis, Bronchitis, Osteoarthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from July, 19 79, to January 4, 19 86, that (I) (we) last saw the deceased alive on January 3, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles M. Hourigan MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 4 Jan 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1-7-86	23c. NAME OF CEMETERY OR CREMATORY: North East Meth.	23d. LOCATION CITY OR TOWN COUNTY STATE: North East Cecil Md.
24. FUNERAL DIRECTOR NAME: Crouch Funeral Home ADDRESS: North East, Md.		25a. DATE REC'D. BY REGISTRAR: JAN 8 1986	25b. REGISTRAR'S SIGNATURE: Jane Dunlap Hopkins

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

017152

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01881
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOSEPH B. ROSSITER	JANUARY 12, 1986	12:40P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White	3 24 1895	90 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. BALTIMORE CITY OR COUNTY OF DEATH
Delaware	USA	MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Cecil MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
PERRY POINT, MD	VA MEDICAL CENTER	Core Maker	Lord & Scott Brass Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Delaware	New Castle	New Castle	YES ☒ NO ☐	43 Queen Ave., 19720

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Joseph Rossiter	Hannamary Wells

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	5/24/18 - 1/23/19	221-01-9903	Margaret E. Gunther	43 Queen Ave., New Castle, DE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 12, 19 85, to JANUARY 12, 19 86, that (I) (we) last saw the deceased alive on JANUARY 12, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Michael Delahunt, M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL DELAHUNT, M.D.	VA MEDICAL CENTER, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/15/86	Mt. Salem Cemetery	Wilmington / New Castle / Delaware

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MCCRERY FUNERAL HOME, WILMINGTN, DE.	JAN 14 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in all its parts, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

013053

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 018 82
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Earl B. MIDDLE LAST Screven		2a. DATE OF DEATH MONTH DAY YEAR January 7, 1986	2b. HOUR 6:38A M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR July 19, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk	12b. KIND OF BUSINESS OR INDUSTRY US Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Prince George's	Clinton	YES ☒ NO ☐	6821 Crafton Lane 20735

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Samuel Screven	Carrie Mackey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	251 07 7823	VAMC, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest; pneumonia, bilateral

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Alzheimer's disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from 2-7-84, to 1-7-86, that ~~I~~ (we) last saw the deceased alive on 1-7-86, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I (we) did not view the body after death~~

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C. Berchelmann	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	1-7-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHRIS BERCHELMANN, M.D.	VAMC, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	01-10-86	Arlington National Cem	Arlington Arl. Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Clinton, Md. 6633 Old Alexander Ferry Road Clinton, Md. 20735	JAN 9 1986	[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please insert carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

027060

STATE OF MARYLAND 8 6 0 1 8 8 3

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: BERTHA G. SIMMS		2a. DATE OF DEATH MONTH DAY YEAR: 1/21/86	2b. HOUR: 6:15 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 2 8 1923	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.
10. CITY OR TOWN OF DEATH: CONOWINGO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5 PARKWAY, PO BOX 208	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	CECIL	CONOWINGO	YES ☐ NO ☒	5 PARKWAY, PO BOX 208

14. FATHER'S NAME FIRST / MIDDLE / LAST: JOHN J. QUICK		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: TRESSIE I. HAYSLETT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): — — — —	16b. SOCIAL SECURITY NO.: 234-56-5615	17. INFORMANT: PERRY MILTON SIMMS — ADDRESS: (SAME AS 13B)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic

DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/20, 19 86 to 1/20/86, 19 ____ that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante N. Monakil	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONAKIL	22e. ADDRESS: HAVRE DE GRACE, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 1-23-86	23c. NAME OF CEMETERY OR CREMATORY: GREENBRIER MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN: LEWISBURG COUNTY: GREENBRIER STATE: W.VA
24. FUNERAL DIRECTOR NAME: R.T. FORD FUNERAL HOME	ADDRESS: RISING SUN MD 21911	25a. DATE REC'D. BY REGISTRAR: JAN 23 1986	25b. REGISTRAR'S SIGNATURE: Esther Davidson-Kendall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DHMH-16 60M 1/73

(VR A 15 (4))

7cc

028061

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01884

1. DECEASED NAME (TYPE OR PRINT) FIRST Verla MIDDLE P. LAST Smith.		2a. DATE OF DEATH MONTH 1/ DAY 14/ YEAR 86	2b. HOUR 1255 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 18 YEAR 1903	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.
10. CITY OR TOWN OF DEATH ELKTON.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
DE	NC	Newark	YES ☒ NO ☐	93 S. Chapel ST. 19711

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Albert Hamilton	Myrtle SEgars Hamilton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		221-18-8568	Norris Smith	11 E. Market St. Port Penn, DE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL REGURGITATION

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/9, 19 86, to 1/14, 19 86, that (I) (we) last saw the deceased alive on 1/14, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
E Rahman	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/17/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EHSANUR RAHMAN	2102 DRUMMOND PLAZA NEWARK, DE 19711

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/18/86	Hd of Christiana	Newark NC DE

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald S. Hicks	Hicks Funeral Home, Elkton, MD	JAN 24 1986	[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 4 is to be retained at office of funeral, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 999999

DHMH - 16 60M 7/84
(VRA 15, 4)

034046

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 01885

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Jane Bartaby Stein		2a. DATE OF DEATH MONTH DAY YEAR: January 28, 1986	2b. HOUR: 22:20 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 11, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England	7b. CITIZEN OF WHAT COUNTRY?: England	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Cecil	North East	YES [X] NO [ ]	300 Merrey St. 21901

14. FATHER'S NAME FIRST MIDDLE LAST: Joseph Fisher	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Blanche Thoms
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 562-44-6332
17. INFORMANT: Clinton H. Stein	ADDRESS: 300 Merrey St. North East, Md. 2190

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Cancer of Bladder with metastases	months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Esophageal Stricture, Anemia, Urinary Tract Infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from January 1, 1979, to January 28, 1986, that (I) (we) last saw the deceased alive on January 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles M. Slaughter	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 28 Jan 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 1-29-86	23c. NAME OF CEMETERY OR CREMATORY: R.A. Ferris & Co.	23d. LOCATION CITY OR TOWN COUNTY STATE: West Chester Chester Pa.

24. FUNERAL DIRECTOR NAME: Crouch Funeral Home ADDRESS: North East, Md. Robert G. Crouch	25a. DATE REC'D. BY REGISTRAR: JAN 30 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and delivered within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered to him by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 7/77 (VR A 15 (4))

017047

STATE OF MARYLAND 86 01886
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Ruth MIDDLE E LAST Thomas

2a. DATE OF DEATH MONTH DAY YEAR 1/6/86

2b. HOUR 0206 AM

3. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR July 23, 1906

6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.

IF UNDER 1 YEAR MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Uniontown, Pa.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.

10. CITY OR TOWN OF DEATH ELKTOW

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary

12b. KIND OF BUSINESS OR INDUSTRY Corp. Chrysler

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md.

13b. COUNTY Cecil

13c. CITY OR TOWN Elkton

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE 65 Irwin Avenue 21921

14. FATHER'S NAME FIRST Frederick MIDDLE E. LAST Addis

15. MOTHER'S MAIDEN NAME FIRST Mildred MIDDLE LAST Liston

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 295-24-9902

17. INFORMANT Doris Lewis ADDRESS 570 W. Lewis Shore Rd., Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia & CAD

DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration, Depression

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from June 19 63, to 1/6 19 86, that (I) (we) last saw the deceased alive on 1/6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Joel S. Lanzi DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 1/6/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph S. LANZI, MD

22e. ADDRESS 721 Bridge Street ELKTON Md 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 1-9-86

23c. NAME OF CEMETERY OR CREMATORY Bethel Cem.

23d. LOCATION CITY OR TOWN Chesapeake City COUNTY Cecil STATE Md.

24. FUNERAL DIRECTOR NAME See Funeral Home, P.A. ADDRESS Elkton, md

25a. DATE REC'D. BY REGISTRAR JAN 9 1986

25b. REGISTRAR'S SIGNATURE Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining carbon-papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

B

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

031128

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01887
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Joanna MIDDLE: M. LAST: Tichnell		2a. DATE OF DEATH MONTH DAY YEAR: Jan 21, 1986	2b. HOUR: 4:25 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 6 26 1937	6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County, MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 40 Middle Road, Elkton, Md.21921	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House Wife	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elk ton	13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 40 Middle Rd., Elkton, Md. 21921
14. FATHER'S NAME FIRST: Henry MIDDLE: LAST: Taylor		15. MOTHER'S MAIDEN NAME FIRST: Georgia MIDDLE: Helmick LAST:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No.	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 235 66 8823	17. INFORMANT: Willard M. Tichnell, ADDRESS: 40 Middle Rd.Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CACHEXIA

DUE TO, OR AS A CONSEQUENCE OF (b) ANEMIA

DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE BREASTS, METASTATIC

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12-14, 19 85, to 12-19, 19 85, that (I) (we) last saw the deceased alive on 12-19, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Rolanda A. Najera	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 1-21-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Rolanda A. Najera, M.D.	22e. ADDRESS: 105 E. Main St., Elkton, Md. 21921	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/24/86	23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception	23d. LOCATION CITY OR TOWN: Elkton, COUNTY: Cecil, STATE: Md.
24. FUNERAL DIRECTOR NAME: HICKS HOME FOR FUNERALS ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR: JAN 29 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

Joanna K. Ticknell Jan 21, 1959 4:25 a

Female White F 26 1923

West Virginia U. S. A. X Cecil County,

Elkton 40 Middle road, Elkton, Md.21921 house wife

Maryland Cecil ELKTON X 40 Middle Rd., Elkton, Md.

Henry Taylor Georgia Melnick

No. William K. Ticknell, 40 Middle Rd.Elkton

Olanda A. Majors , .D. 105 . Main St., Elkton, Md. 21921

Burial 1/24/60 Immaculate Conception Elkton, Cecil Md.

017029

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01888

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Celestine Trimble		2a. DATE OF DEATH MONTH DAY YEAR: 1 13 86	2b. HOUR: 7:20 a.m.
3. SEX: femal e	4. RACE: caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 11 16 25	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL COUNTY MD.
10. CITY OR TOWN OF DEATH: PERRYVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 223 McLHINNEY STREET	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET)REGISTERED NURSE	12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Perryville	YES [X] NO [ ]	223 McLhinney St. 21903

14. FATHER'S NAME FIRST / MIDDLE / LAST: John Kalanik		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Mary Petro	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 208 16 9257	17. INFORMANT: CHARLES M. TRIMBLE, JR. — ADDRESS: SAME AS #13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Extensive atherosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (b) CVA, - Extensive decubitus ulcer on the back

DUE TO, OR AS A CONSEQUENCE OF (c) Aplastic anemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/5, 19__, to __, 19__, that (I) (we) last saw the deceased alive on __, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Brian T. Yeo — DEGREE: ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]		22c. DATE SIGNED: 1/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Brian T. Yeo, M.D.	22e. ADDRESS: 801 S. Union Ave., Havre de Grace, Md. 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 16JANUARY86	23c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN / COUNTY / STATE: ALDINO, HARFORD CO., MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HOME, PA. HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR: JAN 14 1986	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

031125

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01889
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST JOHN MIDDLE W. LAST WHITE		2a. DATE OF DEATH MONTH DAY YEAR Jan. 23,1986	2b. HOUR 2113 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 21,1932	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS 626 Augustine Herman Hgwy
14. FATHER'S NAME FIRST John MIDDLE LAST White			15. MOTHER'S MAIDEN NAME FIRST Myrtle MIDDLE LAST Tuggle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT Evelyn M. White	ADDRESS 626 Augustine Herman Highway Elkton, Md.2192

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Malignant- Melanoma

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 19 86, to Jan. 23, 19 86, that (I) (we) last saw the deceased alive on Jan. 20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Yogish A. Patel	DEGREE MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 1/24/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish Patel MD		22e. ADDRESS 1700 Shallcross Ave. Wilmington,Del.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/26/86	23c. NAME OF CEMETERY OR CREMATORY Kemblesville Cem.	23d. LOCATION CITY OR TOWN Kemblesville, COUNTY Chester, STATE Pa.
24. FUNERAL DIRECTOR NAME Robert T. Jones ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 29 1986	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

042072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 86 01890

1. DECEASED NAME (TYPE OR PRINT): FIRST PERCY; MIDDLE Carl (P.C.); LAST WILLIAMS, Jr.

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 1 DAY 31 YEAR 19 86

2b. HOUR M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH Dec. DAY 20, YEAR 1915

6. AGE (IN YEARS LAST BIRTHDAY): YRS. 70 years; IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 31 YEAR 19 86

2d. HOUR 10:28 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Sault Ste. Marie, Mich. U.S.A.

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Serviceman

12b. KIND OF BUSINESS OR INDUSTRY: Gas Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 285 Hilltop Road 21921

14. FATHER'S NAME: FIRST Percy; MIDDLE Carr; LAST Williams

15. MOTHER'S MAIDEN NAME: FIRST Pearl; MIDDLE; LAST Greenwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217-05-3862

17. INFORMANT: Nellie V. Williams ADDRESS: 285 Hilltop Rd., Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

Chronic obstructive pulmonary disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-1-86

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-5-86

23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.

23d. LOCATION CITY OR TOWN: Elkton COUNTY: Cecil STATE: Md.

24. FUNERAL DIRECTOR NAME: See Funeral Home ADDRESS: Elkton, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 05 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rendell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))